CHILDREN'S THERAPY CENTER
Celebrate what is. Commit to what can be.

Child's Name:
Date of Birth:

Welcome to Children's Therapy Center! We hope you will find CTC to be a warm and welcoming environment for you and your child. Enclosed is the paperwork needed for your visit. Please complete it thoroughly. Let us know if you have any questions or if we can assist you in any way.

ACKNOWLEDGEMENT OF POLICIES AND NOTICE OF PRIVACY PRACTICES

ATTENDANCE POLICY: Since this time is reserved for you and your child, attendance is very important. We understand that illness, medical appointments, travel, and life circumstances create valid reasons for missed appointments; however, we cannot hold recurring appointment times for families who are frequently absent. Please keep the following in mind:

In order to keep the appointment time reserved for you and your child, you must maintain good attendance. We would appreciate at least 24 hours' notice if you are going to miss an appointment. **We require at least 4 hours' notice in advance of missed appointments**. We also ask that you attend at least 75% of your scheduled appointments. Appointments that are missed without calling at least 4 hours prior to your appointment or an attendance rate under 75% will result in the rest of your appointments being cancelled**.**

Thank you for your consideration with regards to appointment attendance.

ASSIGNMENT OF INSURANCE BENEFITS & FINANCIAL AGREEMENT: In order to bill your insurance, all children need a doctor's prescription and insurance authorization prior to their first appointment. Our billing department will work to obtain this information and will contact you with any questions or concerns. We encourage you to contact your insurance company to understand your individual benefits. If you have a co-pay, it will be due at the time of your appointment. Please be sure to inform us of any changes in your insurance plan so that we can continue to bill your insurance appropriately. If you fail to give us prior notice of any change of insurance coverage you will be held responsible for any charges accrued.

NOTICE OF PATIENT PRIVACY PRACTICES: Children's Therapy Center's Notice of Patient Privacy Practices describes how your medical information may be used and disclosed, and how you can get access to this information. Please review this information. CTC reserves the right to update its practices regarding the protected health information that it maintains. You may request a copy of CTC's Notice of Patient Privacy Practices at any of our locations, or online at www.ctckids.org.

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1. By signing below, I hereby assign and authorize payment of medical insurance benefits, in an amount not to exceed the charges for its services, directly to Children's Therapy Center. I understand that it is my responsibility to inform the organization of any changes to my insurance. I also understand that I am financially responsible for any charges not paid under this assignment and agree to pay such charges.
2. By signing below, I acknowledge that I have read and understand Children's Therapy Center's attendance policy, assignment of benefits, financial agreement, and privacy practices.

Signature of Parent or Legal Guardian Date

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Phone: 253-854-5660
Fax: 253-854-7025
www.ctckids.org

Kent
10811 SE Kent-Kangley Rd.
Kent WA 98030

Burien
127 SW 156th St.
Burien, WA 98166

Tacoma
8717 S Hosmer St.
Tacoma, WA 98444

RELEASE OF INFORMATION

I, **(Parent/Guardian)**_____, hereby grant consent for Children's Therapy Center to give and/or receive information pertaining to the Physical/Occupational/Communication/Oral Motor Therapy, Prosthetic/Orthotic programs and/or Education programs for (**Child's Name**) _____ **(other names known by)** _____ (**Child's Date of Birth)**_____ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

Please list names of people who help you with your child, including primary physician, public health nurse, therapists, specialists, day care staff, and other agencies:

Contact Person's Name	Agency/Clinic Name and Address	Phone #
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
Caseworker:		
Physical/Occupational/Speech Therapist:		
Childcare/Daycare Provider:		
Other:		

Rights: I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for the organization to share information regarding the patient on my behalf. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____ _____
Signature of Parent or Legal Guardian **Relationship to Child** **Date**

Expiration: This release will be valid for the patient's duration of participation in our programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.

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Child's Name _____ **DOB** _____

School/Preschool _____ **Grade** _____

What are your primary concerns regarding your child's development?

Please list any medical diagnoses given to your child (Down Syndrome, Cerebral Palsy, Autism, reflux, allergies, etc):

Please list all medications your child takes:

Please list the physicians/professionals/clinics/agencies presently involved in your child's care:
(Children's, Mary Bridge , WIC, other agency)

PREGNANCY/LABOR & DELIVERY

Y N Problems with mother or baby during pregnancy?
Please explain _____
_____

Y N Premature? How many weeks? _____
Gestational age at birth:_____ Wt_____ L _____

Y N At birth did your child have complications?
Please explain _____
_____

Y N Did your child have jaundice?

DEVELOPMENT

Did your child:

Y N Sit unassisted by age 9 months?
Y N Crawl by age 11 months?
Y N Walk unassisted by age 17 months?
Y N Babble by age 6 months?
Y N Speak single words by age 18 months?
Y N Speak in 2-3 word sentences by age 24 months?
Y N Complete toilet training by age 3 years?
Y N Self feed finger food by age 12 months?

FEEDING

Y N Nutritional/feeding concerns?
If yes, please describe: _____
_____

Y N Feeding Tube?

GENERAL HEALTH

Has your child ever had:

Y N Brain injury or seizures?
Y N Meningitis/encephalitis?
Y N Hospitalization, high fever or other serious illness, or injury?
If so, please describe:_____
Y N Allergies? Please describe: _____

HEARING AND VISION

Has your child ever had:

Y N A formal vision test?
When?_____Where?_____
Describe vision test results:
_____

Y N A formal hearing test?
When? _____ Where?_____
Describe hearing test results:_____
_____

Y N Does your child currently wear glasses?
Y N Does your child have ear tubes or hearing aids?

PREVIOUS EVALUATIONS

Y N Speech/language been tested?
Where/When?_____

Y N Has the child been tested for PT or OT?
Where/When?_____

Y N Reports available?

Parent/ Guardian Signature _____ Date _____

Public Health Seattle-King County
Children with Special Health Care Needs Intake Form

CHILD'S NAME: LAST, FIRST MI ***(PLEASE PRINT CLEARLY)***	**CHILD'S DATE OF BIRTH: MM/DD/YYYY:**	**GENDER (please circle) M or F**

CITY OF RESIDENCE:	**YOUR ZIP CODE**

GROSS MONTHLY INCOME: please check which level or provide the dollar amount and number of people in your home:
Our income is less than 210% of the Federal Poverty Level _____
Our income is more than 210% of the Federal Poverty Level _____
OR
Number of people living in your home: _____
Average **monthly** income for this household: _____

Eligibility for state Apple Health plans is based on income and the number of family members in the home.

RACE: Please check one:
- ☐ Asian
- ☐ Black/African Am
- ☐ Native American
- ☐ Alaska Native
- ☐ Hispanic
- ☐ White
- ☐ Multi-racial
- ☐ decline

COUNTY OF RESIDENCE:
- ☐ **KING**,
- ☐ **SNOHOMISH,**
  OR
- ☐ **PIERCE**

INSURANCE COVERAGE: please check those that apply

☐ **Apple Health (aka Medicaid/Provider One)**
(If your child has a Provider One number, please provide it or a copy of your Provider One card)
**** PROVIDER ONE NUMBER: _____WA (**REQUIRED INFORMATION)**

☐ **Private insurance through parent(s) employer, not through state.**

☐ **Tri-Care (CHAMPUS – military)** ☐ **None**

DIAGNOSIS I	**ICD-10 CODE**	**DIAGNOSIS II**	**ICD-10 CODE**

COMMUNITY AGENCIES MY CHILD RECEIVES SERVICES THROUGH:
- ☐ **WIC**
- ☐ **SOCIAL SECURITY INCOME/DISABILITY**
- ☐ **DIVISION OF DEVELOPMENTAL DISABILITIES**
- ☐ **CHILDREN'S HOSPITAL (Includes Mary Bridge)**
- ☐ **FOSTER CARE**
- ☐ **PUBLIC SCHOOLS**
- ☐ **BIRTH TO THREE PROGRAM**

WHICH BIRTH TO THREE PROGRAM IS PROVIDING SERVICES:
- ☐ **Birth to Three Center Federal Way**
- ☐ **Boyer Children's Clinic**
- ☑ **Children's Therapy Center (Kent)**
- ☐ **Kindering Center**
- ☐ **Mary Bridge Neuro-developmental Program**
- ☐ **Valley Medical Center - CTU**

Children with Special Health Care Needs program (CSHCN) is a state and federally funded Title V program offered through Public Health, Seattle-King County. The CSHCN program provides the above information to the state for statistical purposes and coordination of care through the Health Care Authority
.

☐ **I authorize this information be provided to Public Health Seattle-King County, Children with Special Health Care Needs program**

_____ _____ _____/____/_____
Signature of parent/guardian **Relationship to child** **Date**

Children with Special Health Care Needs
Public Health, Seattle-King County
401 Fifth Ave; Suite 1000
Seattle, WA 98104-1818
Phone: 206-296-4610 Fax: 206-296-4679

Public Health
Seattle & King County

As a nonprofit agency, we receive funding from United Way. We are requested by United Way to collect demographic information for participants in our program. This survey does not include your name so that your identity is totally confidential. Please take a few moments to complete this form. Thank you!

Client Demographic Form July 2015 - June 2016

Instructions: *Please write clearly. Enter numbers or mark **X** in the appropriate boxes.*

1. Geographic Region:
We live in
Zip Code: [9][8][ ][ ][ ]

We live OUTSIDE the city limits:
☐ YES ☐ NO

2. Household Composition
Please check one:
- ☐ Two parent household
- ☐ Single parent (male)
- ☐ Single parent (female)
- ☐ Other related household

3. Total Gross Household Income
Please check one **based on the chart below**:
- ☐ Under 30% of Median Income (A)
- ☐ Under 50% of Median Income (B)
- ☐ Under 80% of Median Income (C)
- ☐ Equal or Above 80% of Median Income (D)

4. Are you currently homeless? (check one)
☐ YES ☐ NO

5. Child's Age: [ ][ ] Years [ ][ ] Months

6. Child's Gender: (check one)
☐ Female ☐ Male

7. Ethnicity:
Child is Spanish / Hispanic / Latino
☐ YES ☐ NO

8. Child's Race: (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian, Asian American
- ☐ Black, African American, Other African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ Other

9. Refugee/Immigrant: Is the child an immigrant, refugee or new arrival to this country?
☐ YES ☐ NO

10. Limited English Proficiency
Are you (parent/adult) limited in your ability to communicate in English? (check one)
☐ YES ☐ NO

King County - HUD Income Guidelines - 2015

Instructions: Under FAMILY SIZE, choose the row for the number of people in your household. Select the income range in that row for your ANNUAL GROSS INCOME for last year. The letter above that column will be your income category.

	Percent of Median Income			
FAMILY SIZE ↓↓↓	**30% HUD PMSA Very Low Category A**	**50% HUD PMSA Low Category B**	**80% HUD PMSA Moderate Category C**	**Over 80% HUD PMSA Above Moderate Category D**
1 Person	Up to $ 18,850	$ 18,851 to $ 31,400	$ 31,401 to $ 46,100	$ 46,101 or more
2 Persons	Up to $ 21,550	$ 21,551 to $ 35,850	$ 35,851 to $ 52,650	$ 52,651 or more
3 Persons	Up to $ 24,250	$ 24,251 to $ 40,350	$ 40,351 to $ 59,250	$ 59,251 or more
4 Persons	Up to $ 26,900	$ 26,901 to $ 44,800	$ 44,801 to $ 65,800	$ 65,801 or more
5 Persons	Up to $ 29,100	$ 29,101 to $ 48,400	$ 48,401 to $ 71,100	$ 71,101 or more
6 Persons	Up to $ 32,570	$ 32,571 to $ 52,000	$ 52,001 to $ 76,350	$ 76,351 or more
7 Persons	Up to $ 36,730	$ 36,731 to $ 55,600	$ 55,601 to $ 81,600	$ 81,601 or more
8 Persons	Up to $ 40,890	$ 40,891 to $ 59,150	$ 59,151 to $ 86,900	$ 86,901 or more

FY 2015, Median 4 Person Family income = $89,548
HUD (U.S. Department of Housing and Urban Development) rev 8/2015
PMSA (Primary Metropolitan Statistical Areas)

United Way
King and Pierce County

Thank you for your reply.

Your information will be kept completely confidential.